Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL QUALITY MEASURES CLEARINGHOUSE

General

Title

Chronic stable coronary artery disease: percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have prior MI or a current or prior LVEF less than 40% who were prescribed beta-blocker therapy.

Source(s)

American College of Cardiology Foundation (ACCF), American Heart Association (AHA), American Medical Association-convened Physician Consortium for Performance ImprovementÂ® (PCPIÂ®). Chronic stable coronary artery disease performance measurement set. Chicago (IL): American Medical Association (AMA); 2016 Mar. 35 p. [20 references]

Measure Domain

Primary Measure Domain

Clinical Quality Measures: Process

Secondary Measure Domain

Does not apply to this measure

Brief Abstract

Description

This measure is used to assess the percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have prior myocardial infarction (MI) or a current or prior left ventricular ejection fraction (LVEF) less than 40% who were prescribed beta-blocker therapy.

Rationale

For patients with coronary artery disease (CAD), beta-blockers are recommended for 3 years after myocardial infarction or acute coronary syndrome. Beta-blockers, particularly carvedilol, metoprolol succinate, or bisoprolol, which have been shown to reduce risk of death, are recommended indefinitely for patients with CAD and left ventricular systolic dysfunction (LVSD). These agents have proven efficacy in

reducing angina onset and improving the ischemic threshold during exercise. In patients who have suffered a myocardial infarction (MI), beta-blockers significantly reduce deaths and recurrent MIs (Fihn et al., 2012).

Nonadherence to cardioprotective medications is prevalent among outpatients with CAD and can be associated with a broad range of adverse outcomes, including all-cause and cardiovascular mortality, cardiovascular hospitalizations, and the need for revascularization procedures.

This measure is intended to promote beta-blocker usage in select patients with CAD.

The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and represent the evidence base for the measure:

Beta-blocker therapy should be started and continued for 3 years in all patients with normal left ventricular (LV) function after MI or acute coronary syndrome (ACS) (Fihn et al., 2012).

Beta-blocker therapy should be used in all patients with LV systolic dysfunction (ejection fraction [EF] less than or equal to 40%) with heart failure or prior MI, unless contraindicated. (Use should be limited to carvedilol, metoprolol succinate, or bisoprolol, which have been shown to reduce risk of death) (Fihn et al., 2012).

Evidence for Rationale

American College of Cardiology Foundation (ACCF), American Heart Association (AHA), American Medical Association-convened Physician Consortium for Performance ImprovementÂ® (PCPIÂ®). Chronic stable coronary artery disease performance measurement set. Chicago (IL): American Medical Association (AMA); 2016 Mar. 35 p. [20 references]

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Primary Health Components

Coronary artery disease; myocardial infarction (MI); left ventricular systolic dysfunction (left ventricular ejection fraction [LVEF] less than 40%); beta-blocker therapy

Denominator Description

All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have prior (within the past 3 years) myocardial infarction (MI) or a current or prior left ventricular ejection fraction (LVEF) less than 40% (see the related "Denominator Inclusions/Exclusions" field)

Numerator Description

Patients who were prescribed beta-blocker therapy (see the related "Numerator Inclusions/Exclusions" field)

Evidence Supporting the Measure

Type of Evidence Supporting the Criterion of Quality for the Measure

A clinical practice guideline or other peer-reviewed synthesis of the clinical research evidence

One or more research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal

Additional Information Supporting Need for the Measure

Importance of Topic

Prevalence and Incidence

16.3 million Americans are living with coronary heart disease (Roger et al., 2011). Total coronary heart disease prevalence is 7.0% in adults aged 20 years and older in the United States (U.S.).
Prevalence of coronary heart disease for men is 8.3% and for women is 6.1%.
Coronary heart disease makes up more than half of all cardiovascular events in men and women less than 75 years of age.
The lifetime risk of developing coronary heart disease after age 40 is 49% for men and 32% for women.
The incidence of coronary heart disease in women lags behind men by 10 years for total coronary heart disease and by 20 years for more serious clinical events such as myocardial infarction (MI) and sudden death.

Mortality

While death rates have fallen from 1968 to the present, coronary heart disease is the largest killer of men and women in the U.S. It has been estimated that approximately 47% of this decrease is attributed to treatments (medical and surgical), while approximately 44% is attributed to changes in risk factors.
Coronary heart disease caused approximately 1 of every 6 deaths in the U.S. in 2007.
Approximately 81% of people who die of coronary heart disease are greater than or equal to 65 years of age.
The mortality rate for women age 35 to 44 increased on average by 1.3% per year between 1997 and 2002.
Since 1984, the number of deaths for women has exceeded those for men; in 2005, women represented 52.6% of deaths from coronary heart disease.
People who have had a MI have a sudden death rate 4 to 6 times that of the general population.

Office Visits

2008 data found that the number of ambulatory care visits for coronary heart disease was 16,251,000. The majority of these visits (62.2%) were for coronary atherosclerosis.

Cost

In 2007, the estimated direct and indirect cost for coronary heart disease in the U.S. is $177.5 billion.
In 2006, coronary artery disease was the most expensive condition treated in U.S. hospitals at a cost of $52.6 billion (Andrews, 2008) and accounted for 5% of total hospitalization costs (Levit et al., 2008).
Thirty percent of Medicare's total expenditures are applied to cardiovascular disease (Centers for Medicare and Medicaid Services [CMS], 2008).
In 2007, $5.2 billion was spent on outpatient visits related to chronic ischemic heart disease (Trogdon et al., 2007).

Opportunity for Improvement

According to a study analyzing the quality of care in the U.S., on average, patients with coronary artery disease received the recommended quality of care 68% of the time (McGlynn et al., 2003). Quality of care was assessed by analysis of clinician performance on thirty-seven coronary artery disease quality indicators. Quality of care varied significantly by indicator with average rates of adherence ranging from 29.13% for counseling for smoking cessation at the time of coronary artery disease diagnosis to 100% for left ventricular ejection fraction (LVEF) assessment of patients hospitalized with MI either during hospitalization or within two weeks of hospital discharge.

A study conducted by Ho et al. (2008) found that nonadherence to cardioprotective medications was prevalent among outpatients with coronary artery disease and was associated with a broad range of adverse outcomes, including all-cause and cardiovascular mortality, cardiovascular hospitalizations, and the need for revascularization procedures. Although there have been improvements in the prescription rates of secondary prevention medications for coronary artery disease patients, a gap persists between the benefits demonstrated with these medications in clinical trials and the effectiveness observed in clinical practice. One potential explanation for this discrepancy is suboptimal adherence to secondary prevention medications in practice compared with clinical trials, where adherence is often closely monitored.

> Over a median follow up of 4.1 years, medication nonadherence to statins, angiotensin-converting enzyme (ACE) inhibitors, and beta-blockers was common, occurring in approximately 1 in 4 patients.
> Among patients dispensed beta-blockers (n = 11,865), 28.8% were nonadherent.
> For patients dispensed ACE inhibitors or angiotensin-receptor blockers (ARBs) (n = 10,021), 21.6% were nonadherent.
> For patients taking statin medications (n = 13,596), 26.0% were nonadherent.

In another study conducted by Apikoglu Rabus and colleagues, 73 patients who were diagnosed to have coronary artery disease were followed up for 5 years. They concluded there was suboptimal prescribing of secondary prevention drugs and absence of continuity of prescribing these secondary prevention drugs in the pharmaceutical care of coronary artery disease patients.

> The 'initial prescribing rate' at discharge was found to be 82% for aspirin, 49% for statins, 44% for ACE inhibitors and 55% for beta-blockers.
> 'Continuity of prescribing' for 5 years was 45% for aspirin, 26% for statins, 17% for ACE inhibitors and 20% for beta-blockers (Apikoglu Rabus et al., 2008).

Cardiac rehabilitation programs remain underused. In the U.S., only 10% to 20% of the 2 million eligible patients per year who experience MI or underwent cardiac revascularization procedures participated in cardiac rehabilitation programs (Spronk et al., 2008).

Measure Importance

Opportunity for Improvement

Suboptimal rates of beta-blocker prescriptions among patients with coronary artery disease (CAD) are evidenced by several recent studies.

Maddox and colleagues analyzed data from 2008 through 2010 from the National Cardiovascular Data (NCDR) PINNACLE Registry®, a national outpatient cardiology practice registry, to assess practice variation of secondary prevention medication prescription among CAD patients. Among eligible patients, beta-blockers were prescribed in 73.3% (63,800/86,999) at their index clinic visit. After inclusion of all visits among eligible patients occurring within the year following the index visit, the rates increased to 77.3%. Among practices, the median prescription rate of beta-blockers for eligible patients at their index clinic visit was 78.4% (range 35.2 to 100%) and 79.4% (range 46.2 to 100%) after inclusion of all visits among eligible patients occurring within the year following the index visit (Maddox et al., 2014).

An earlier study by Chan and colleagues analyzed 2008 to 2009 data from the Pinnacle registry and found slightly higher rates (86.4%) of beta-blocker prescription among CAD patients following an MI (Chan et al., 2010).

It's important to note that the Chan et al. study examined compliance rates with performance measures among the first 14,000 outpatients enrolled in the PINNACE program as compared to the Maddox et al. study which included a larger and more heterogeneous patient and practice population.

Evidence for Additional Information Supporting Need for the Measure

American College of Cardiology Foundation (ACCF), American Heart Association (AHA), American Medical Association-convened Physician Consortium for Performance ImprovementÂ® (PCPIÂ®). Chronic stable coronary artery disease performance measurement set. Chicago (IL): American Medical Association (AMA); 2016 Mar. 35 p. [20 references]

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Extent of Measure Testing

The American Medical Association (AMA)-convened Physician Consortium for Performance Improvement (PCPI) collaborated on several measure testing projects in 2004, 2009 and 2015 to ensure the *Coronary Artery Disease–Beta Blocker Therapy Prior to Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVSD)* measure is reliable and evaluated for accuracy of the measure denominator, numerator and exception case identification. The testing projects were conducted utilizing electronic health record data and registry data. Parallel forms reliability and signal-to-noise reliability was tested.

One site participated in the parallel forms testing of the *Coronary Artery Disease–Beta Blocker Therapy Prior to MI or LVSD* measure. Site A was an academic general internal medicine clinic with several years of experience using a commercial electronic health record (EHR). The clinic employs 40 full or part-time internal medicine physicians and provides more than 41,000 patient visits annually.

Signal-to-noise reliability was assessed using 2013 data acquired from the Centers for Medicare & Medicaid Services Physician Quality Reporting System Group Practice Reporting Option (GPRO) database.

Measures Tested

- Coronary Artery Disease–Beta Blocker Therapy Prior to MI or LVSD

Reliability Testing

The purpose of reliability testing was to evaluate whether the measure definitions and specifications, as prepared by the PCPI, yield stable, consistent measures. Data abstracted from electronic health records were used to calculate parallel forms reliability for the measures and data acquired from the GPRO database were used to perform signal-to-noise reliability for the measures.

Reliability Testing Results

Coronary Artery Disease–Beta Blocker Therapy Prior to MI or LVSD

Parallel Forms Reliability Testing (Site A)

There were 134 observations from Site A included as part of the analysis. Of the 134 patients sampled via automated EHR review, 111 patients (82.8%) meeting the numerator criteria were detected. Performance on the measure was calculated to be 90.3% through comparison of automated and manual EHR review.

Discrepancies between performance measures based on EHR automated review alone and those based on automated review plus manual reviews were due to two types of misclassification: failure to correctly identify performance of quality measures among true, eligible patients; and failure to correctly exclude patients. Upon further analysis, the differences between automated review alone and automated plus manual reviews were 10 patients (7.5%).

Signal-to-Noise Reliability Testing

GPRO Registry

For this measure, the reliability at the minimum level of quality reporting events (10) was 0.65. The average number of quality reporting events for physicians included is 61.0. The reliability at the average number of quality reporting events was 0.92.

This measure has moderate reliability when evaluated at the minimum level of quality reporting events and high reliability at the average number of quality events.

Evidence for Extent of Measure Testing

American College of Cardiology Foundation (ACCF), American Heart Association (AHA), American Medical Association-convened Physician Consortium for Performance ImprovementÂ® (PCPIÂ®). Chronic stable coronary artery disease performance measurement set. Chicago (IL): American Medical Association (AMA); 2016 Mar. 35 p. [20 references]

State of Use of the Measure

State of Use

Current routine use

Current Use

not defined yet

Application of the Measure in its Current Use

Measurement Setting

Ambulatory/Office-based Care

Home Care

Hospital Inpatient

Long-term Care Facilities - Other

Skilled Nursing Facilities/Nursing Homes

Professionals Involved in Delivery of Health Services

not defined yet

Least Aggregated Level of Services Delivery Addressed

Individual Clinicians or Public Health Professionals

Statement of Acceptable Minimum Sample Size

Does not apply to this measure

Target Population Age

Age greater than or equal to 18 years

Target Population Gender

Either male or female

National Strategy for Quality Improvement in Health Care

National Quality Strategy Aim

Better Care

National Quality Strategy Priority

Prevention and Treatment of Leading Causes of Mortality

Institute of Medicine (IOM) National Health Care Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Data Collection for the Measure

Case Finding Period

12 month period

Denominator Sampling Frame

Patients associated with provider

Denominator (Index) Event or Characteristic

Clinical Condition

Encounter

Patient/Individual (Consumer) Characteristic

Denominator Time Window

not defined yet

Denominator Inclusions/Exclusions

Inclusions
All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have prior (within the past 3 years) myocardial infarction (MI) or a current or prior left ventricular ejection fraction (LVEF) less than 40%

Note: Refer to the original measure documentation for administrative codes.

Exclusions
None

Exceptions

- Documentation of medical reason(s) for not prescribing beta-blocker therapy (e.g., allergy, intolerance, other medical reasons)
- Documentation of patient reason(s) for not prescribing beta-blocker therapy (e.g., patient declined, other patient reasons)
- Documentation of system reason(s) not prescribing beta-blocker therapy (e.g., other reasons attributable to the health care system)

Exclusions/Exceptions

not defined yet

Numerator Inclusions/Exclusions

Inclusions
Patients who were prescribed* beta-blocker therapy**

Note: Refer to the original measure documentation for administrative codes.

*Prescribed may include prescription given to the patient for beta-blocker therapy at one or more visits in the measurement period OR patient already taking beta-blocker therapy as documented in current medication list.

**Beta-blocker therapy:

- For patients with prior myocardial infarction (MI), beta-blocker therapy includes any agent within the beta-blocker drug class. As of 2015, no recommendations or evidence are cited in current stable ischemic heart disease guidelines for preferential use of specific agents.
- For patients with prior left ventricular ejection fraction (LVEF) less than 40%, beta-blocker therapy includes the following: bisoprolol, carvedilol, or sustained release metoprolol succinate.

Exclusions
None

Numerator Search Strategy

Fixed time period or point in time

Data Source

Electronic health/medical record

Registry data

Type of Health State

Does not apply to this measure

Instruments Used and/or Associated with the Measure

None

Computation of the Measure

Measure Specifies Disaggregation

Does not apply to this measure

Scoring

Rate/Proportion

Interpretation of Score

Desired value is a higher score

Allowance for Patient or Population Factors

not defined yet

Standard of Comparison

not defined yet

Identifying Information

Original Title

Measure #7: beta-blocker therapy—prior myocardial infarction (MI) or left ventricular systolic dysfunction (LVEF <40%).

Measure Collection Name

AMA/PCPI Chronic Stable Coronary Artery Disease Performance Measurement Set

Submitter

American Medical Association - Medical Specialty Society

Developer

Physician Consortium for Performance ImprovementÂ® - Clinical Specialty Collaboration

Funding Source(s)

Unspecified

Composition of the Group that Developed the Measure

Chronic Stable Coronary Artery Disease Measure Development Work Group*

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*The composition and affiliations of the work group members are listed as originally convened in 2011 and are not up-to-date.

Financial Disclosures/Other Potential Conflicts of Interest

Conflicts, if any, are disclosed in accordance with the Physician Consortium for Performance Improvement® conflict of interest policy.

Endorser

National Quality Forum - None

NQF Number

not defined yet

Date of Endorsement

2016 Feb 26

Core Quality Measures

Cardiology

Measure Initiative(s)

Physician Quality Reporting System

Adaptation

This measure was not adapted from another source.

Date of Most Current Version in NQMC

2016 Mar

Measure Maintenance

Coding/Specifications updates occur annually. The Physician Consortium for Performance Improvement (PCPI) has a formal measurement review process that stipulates regular (usually on a three-year cycle, when feasible) review of the measures. The process can also be activated if there is a major change in scientific evidence, results from testing or other issues are noted that materially affect the integrity of the measure.

Date of Next Anticipated Revision

2017 Apr

Measure Status

This is the current release of the measure.

This measure updates a previous version: American College of Cardiology Foundation, American Heart Association, Physician Consortium for Performance Improvement®. Chronic stable coronary artery disease performance measurement set. Chicago (IL): American Medical Association (AMA); 2011 Jan. 95 p. [75 references]

Measure Availability

Source available from the American Medical Association (AMA)-convened Physician Consortium for Performance Improvement® Web site .

For more information, contact AMA staff by e-mail at cqi@ama-assn.org.

NQMC Status

This NQMC summary was completed by ECRI on September 26, 2003. The information was verified by the measure developer on January 28, 2004.

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Copyright Statement

Production

Source(s)

American College of Cardiology Foundation (ACCF), American Heart Association (AHA), American Medical Association-convened Physician Consortium for Performance ImprovementÂ® (PCPIÂ®). Chronic stable coronary artery disease performance measurement set. Chicago (IL): American Medical Association (AMA); 2016 Mar. 35 p. [20 references]

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